Supreme Court, U.S.
FILED
APR 10 1992
OFFICE OF THE CLERK

(5)

No. 91-687

IN THE
SUPREME COURT OF THE UNITED STATES
OCTOBER TERM, 1991

STATE OF MONTANA,
Petitioner,

vs.

DONALD GLENN IMLAY,
Respondent.

On Writ of Certiorari to the Montana Supreme Court

BRIEF OF *AMICUS CURIAE* AMERICAN PROFESSIONAL SOCIETY ON THE ABUSE OF CHILDREN SUPPORTING NEITHER PARTY

John E.B. Myers
American Professional Society on the
Abuse of Children
3200 5th Ave.
Sacramento, CA 95817
(916) 739-7176

TABLE OF CONTENTS

	Page
Table of Authorities	iii
Interest of the *Amicus Curiae*	i
Introduction and Summary of Argument	3
Argument	3
I. CHILD SEXUAL ABUSE IS A WIDESPREAD PROBLEM WITH SERIOUS PSYCHOLOGICAL CONSEQUENCES FOR MANY VICTIMS	3
II. SEX OFFENDER TREATMENT IS A COMPONENT OF AN INTEGRATED SOCIETAL RESPONSE TO CHILD SEXUAL ABUSE	8
III. ALTHOUGH SEX OFFENDER TREATMENT IS INCREASINGLY SOPHISTICATED, TREATMENT GENERALLY CANNOT BE EFFECTIVE UNLESS THE OFFENDER ADMITS THE ABUSE	11
A. DENIAL	14
B. COGNITIVE DISTORTION	16
C. INCREASING THE OFFENDER'S ABILITY TO EMPATHIZE WITH THE VICTIM	17
D. RISK FACTORS AND ANTECEDENTS TO SEXUAL ABUSE	17

TABLE OF CONTENTS — Continued

E. INCREASING SOCIAL COMPETENCE..... 18

F. SEXUAL AROUSAL 18

G. SUMMARY 19

CONCLUSION 19

TABLE OF AUTHORITIES

Cases PAGE

Maryland v. Craig, 110 S. Ct. 3157 (1990) 8

Other Authorities

Abel, Becker, Mittelman, Cunningham-Rathner, Rouleau & Murphy, *Self-Reported Sex Crimes of Nonincarcerated Paraphiliacs*, 2 J. Interpersonal Violence 3 (1987) 7

Abel, Mittelman, Becker, Rathner & Rouleau, *Predicting Child Molesters' Response to Treatment*, 528 Annals N.Y. Academy Sciences 223 (1988) 10,13

American Psychological Association, *Ethical Principles of Psychologists* (1990) 14

Barbaree, *Denial and Minimization Among Sex Offenders: Assessment and Treatment Outcome*, 3 Forum on Corrections Research 30 (1991) 14,16

Beitchman, Zucker, Hood, daCosta, Akman & Cassavia, *A Review of the Long-Term Effects of Sexual Abuse*, 16 Child Abuse & Neglect 101 (1992) 4

Berliner, *Effects of Sexual Abuse on Children*, 1 Violence Update 1 (1991) 4,6,7

Bifulco & Adler, *Early Sexual Abuse and Clinical Depression in Adult Life*, 159 British J.Psychiatry 114 (1991) 5

Briere & Runtz, *Symptomatology Associated with Childhood Sexual Victimization in a Non-Clinical Sample*, 12 Child Abuse & Neglect 51 (1988) 6

TABLE OF AUTHORITIES — Continued

Briere & Zaidi, *Sexual Abuse Histories and Sequelae in Female Psychiatric Emergency Room Patients*,146 Am. J. Psychiatry 1602 (1989) 5

California Attorney General's Office, *California Child Victim Witness Judicial Advisory Committee: Final Report* (1988) 8

Chu & Dill, Dissociative Symptoms in Relation to Childhood Physical and Sexual Abuse, 147 Am. J. Psychiatry 887 (1990) 6

D. Finkelhor, *A Sourcebook on Child Sexual Abuse* (1986) 4

Finkelhor & Browne, *The Traumatic Impact of Child Sexual Abuse: A Conceptualization*, 55 Am. J. Orthopsychiatry 530 (1985) 4

Finkelhor, Hotaling, Lewis & Smith, *Sexual Abuse and Its Relationship to Later Sexual Satisfaction, Marital Status, Religion, and Attitudes*, 4 J. Interpersonal Violence 379 (1989) 4,5,6

Friedrich, Grambsch, Broughton, Kuiper & Beilke, *Normative Sexual Behavior in Children*, 88 Pediatrics 456 (1991) 4

Furby, Weinrott, & Blackshaw, *Sex Offender Recidivism: A Review*, 105 Psychological Bulletin 3 (1989) 11

J. Goodwin, *Sexual Abuse: Incest Victims and their Families* (1982) 7

G. Hotaling, D. Finkelhor, J. Kirkpatrick & M. Straus, *Family Abuse and Its Consequences* (1988) 4

Jacobson, *Physical and Sexual Assault Histories Among Psychiatric Outpatients*, 146 Am. J. Psychiatry 755 (1989) 5

TABLE OF AUTHORITIES — Continued

Jacobson & Herald, *The Relevance of Childhood Sexual Abuse to Adult Psychiatric Inpatient Care*, 41 Hospital & Community Psychiatry 154 (1990) 5

Jacobson & Richardson, *Assault Experiences of 100 Psychiatric Inpatients: Evidence of the Need for Routine Inquiry*, 144 Am. J. Psychiatry 908 (1987) 5

Kelley, *Behavioral Reorientation of Pedophiles. Can it be Done?*, 2 Clinical Psychology Review 387 (1992) 19

B. Maletzky, *Treating the Sexual Offender* (1991) 15

B. Maletzky, *Data Generated by an Outpatient Sexual Abuse Clinic.* Paper presented at the 1st Annual Conference on the Assessment and Treatment of Sexual Abusers, Newport, Oregon (May 1987) 13

Marshall & Barbaree, *The Long-Term Evaluation of a Behavioral Treatment Program for Child Molesters*, 26 Behavior Research & Therapy 499 (1988) 13

K. Meiselman, Incest: *A Psychological Study of Causes and Effects With Treatment Recommendations* (1978) 5

Murphy, *Assessment and Modification of Cognitive Distortions in Sex Offenders, in Handbook of Sexual Assault: Issues, Theories, and Treatment of the Offender* (W. Marshall, D. Laws & H. Barbaree eds. (1990) 16

Murphy, Haynes, & Worley, *Assessment of Adult Sexual Interest, in Clinical Approaches to Sex Offenders and Their Victims* (C. Hollin & K. Howells eds. 1991) 18

TABLE OF AUTHORITIES — Continued

Myers, Bays, Becker, Berliner, Corwin & Saywitz, *Expert Testimony in Child Sexual Abuse Litigation*, 68 Neb. L. Rev. 1 (1989) 11

Pithers, *Relapse Prevention with Sexual Aggressors: A Method for Maintaining Therapeutic Gain and Enhancing External Supervision, in Handbook of Sexual Assault: Issues, Theories, and Treatment of the Offender* (W. Marshall, D. Laws & H. Barbaree eds. 1990) 12

Pithers & Cumming, *Can Relapse be Prevented? Initial Outcome Data from the Vermont Treatment Program for Sexual Aggressors, in Relapse Prevention with Sex Offenders* (D. Laws ed. 1989) 13

Pribor & Dinwiddie, *Psychiatric Correlates of Incest in Childhood*, 149 Am. J. Psychiatry 52 (1992) 4

D. Russell, *The Secret Trauma: Incest in the Lives of Girls and Women* (1986) 6

D. Russell, *Sexual Exploitation: Rape, Child Sexual Abuse and Workplace Harassment* (1984) 4

B. Smith, S. Hillenbrand & S. Goretsky, *The Probation Response to Child Sexual Abuse Offenders: How is it Working?* (American Bar Association, Criminal Justice Section 1990) 8,9,10,16

State of Washington, *Governor's Task Force on Community Protection* (1989) 7

Stein, Golding, Siegel, Burnam & Sorenson, *Long Term Psychological Sequelae of Child Sexual Abuse: The Los Angeles Epidemiological Catchment Area Study, in Lasting Effects of Child Sexual Abuse* 135 (G. Wyatt & G. Powell eds. 1988) 6

TABLE OF AUTHORITIES — Continued

U.S. Department of Justice, *A Practitioner's Guide to Treating the Incarcerated Male Sex Offender: Breaking the Cycle of Sexual Abuse* (1988) 16

Wash. Admin. Code 246-930-010, 246-930-301 to 246-930-340 9

Wash. Rev. Code Ann. 9.94A.120(7) (1992 Cum. Pocket Part) 9

Weinrott & Saylor, *Self-Report of Crimes Committed by Sex Offenders*, 6 J. Interpersonal Violence 286 (1991) 7

Wolfe, *Northwest Treatment Associates: A Comprehensive Community-Based Evaluation and Treatment Program for Adult Sex Offenders, in Retraining Adult Sex Offenders: Methods and Models* (F. Knopp ed. 1984) 13

Wyatt, *The Sexual Abuse of Afro-American and White-American Women in Childhood*, 9 Child Abuse & Neglect 507 (1985) 4

IN THE
SUPREME COURT OF THE UNITED STATES
OCTOBER TERM, 1991

No. 91-687

STATE OF MONTANA,

Petitioner,

vs.

DONALD GLENN IMLAY,

Respondent.

On Writ of Certiorari to the Montana Supreme Court

BRIEF OF *AMICUS CURIAE* AMERICAN PROFESSIONAL SOCIETY ON THE ABUSE OF CHILDREN

INTEREST OF THE *AMICUS CURIAE*

The American Professional Society on the Abuse of Children (APSAC) is an interdisciplinary society of professionals working in the fields of child abuse research, prevention, treatment, investigation, litigation, and policy.[1] The purposes of APSAC are to promote effective identification, intervention and treatment of abused children, their

---

1. The information contained in this brief was supplied largely by Lucy Berliner, M.S.W., William D. Murphy, Ph.D., William D. Pithers, Ph.D., and Robert Prentky, Ph.D.

families, and offending individuals. APSAC was founded in 1987 and has more than 2,200 members.

Amicus, with the written consent of the parties, respectfully submits this brief to call the Court's attention to contemporary issues in the psychological treatment of individuals who sexually abuse children. This brief supports neither party, and *Amicus* takes no position on the outcome of the case.

INTRODUCTION AND SUMMARY OF ARGUMENT

Child sexual abuse is a serious and widespread problem in America. Sex offender treatment is a useful alternative to incarceration for certain convicted offenders. For treatment to be effective, however, the offender must admit that the abuse occurred. Efforts to provide meaningful offender treatment will be severely undermined unless offenders can be required to admit the abuse as a precondition to treatment, and unless failure to admit can lead to termination of treatment and revocation of probation or parole. A policy which allows convicted sex offenders both to avoid incarceration and to thwart meaningful treatment by refusing to admit the abuse would pose a serious threat to community safety and effective rehabilitation of offenders.

ARGUMENT

I. CHILD SEXUAL ABUSE IS A WIDESPREAD PROBLEM WITH SERIOUS PSYCHOLOGICAL CONSEQUENCES FOR MANY VICTIMS

Sexual abuse touches the lives of thousands of

children each year in the United States.[2] Research indicates "that as many as 10% to 15% of boys and 20% to 25% of girls experience at least one instance of sexual misuse prior to the age of 18 . . . ."[3] In a nationwide survey of sexually abused children, "[t]he median age at time of abuse was 9.9 years for boys and 9.6 for girls."[4] Child sexual abuse occurs at all ages, however, from infancy to adolescence.

It has long been known that sexual abuse has a negative psychological impact on children. A large and growing body of research describes the short- and long-term effects of child sexual abuse.[5] The long-term consequences of sexual abuse during childhood are devastating for many

---

2. D. Russell, *Sexual Exploitation: Rape, Child Sexual Abuse and Workplace Harassment* (1984); G. Hotaling, D. Finkelhor, J. Kirkpatrick & M. Straus, *Family Abuse and Its Consequences* (1988); Wyatt, *The Sexual Abuse of Afro-American and White-American Women in Childhood*, 9 Child Abuse & Neglect 507 (1985).

3. Friedrich, Grambsch, Broughton, Kuiper & Beilke, *Normative Sexual Behavior in Children*, 88 Pediatrics 456, 462 (1991). See also, D. Finkelhor, *A Sourcebook on Child Sexual Abuse* (1986).

4. Finkelhor, Hotaling, Lewis & Smith, *Sexual Abuse and Its Relationship to Later Sexual Satisfaction, Marital Status, Religion, and Attitudes*, 4 J. Interpersonal Violence 379, 381 (1989).

5. Beitchman, Zucker, Hood, daCosta, Akman & Cassavia, *A Review of the Long-Term Effects of Sexual Abuse*, 16 Child Abuse & Neglect 101 (1992); Berliner, *Effects of Sexual Abuse on Children*, 1 Violence Update 1 (1991); Finkelhor & Browne, *The Traumatic Impact of Child Sexual Abuse: A Conceptualization*, 55 Am. J. Orthopsychiatry 530 (1985); Pribor & Dinwiddie, *Psychiatric Correlates of Incest in Childhood*, 149 Am. J. Psychiatry 52 (1992).

victims.[6] The earliest systematic reports on long-term effects focused on incest victims who were receiving psychotherapy. These reports found that incest survivors have more severe symptoms than psychiatric patients who have not be sexually abused.[7] Later research examined the prevalence of child sexual abuse in adults who are receiving mental health services.[8] The percentage of psychiatric patients who were abused as children was strikingly high. Several studies indicate that over eighty percent of psychiatric inpatients have some kind of abuse history.[9]

Studies of the general, nonpsychiatric population confirm that abuse survivors experience high levels of abuse-

---

6. Finkelhor, Hotaling, Lewis & Smith, *Sexual Abuse and Its Relationship to Later Sexual Satisfaction, Marital Status, Religion, and Attitudes*, 4 J. Interpersonal Violence 379, 380 (1989) ("a history of abuse is a risk factor for adult problems").

7. K. Meiselman, *Incest: A Psychological Study of Causes and Effects With Treatment Recommendations* (1978).

8. Bifulco & Adler, *Early Sexual Abuse and Clinical Depression in Adult Life*, 159 British J. Psychiatry 114 (1991); Briere & Zaidi, *Sexual Abuse Histories and Sequelae in Female Psychiatric Emergency Room Patients*, 146 Am. J. Psychiatry 1602 (1989); Jacobson, *Physical and Sexual Assault Histories Among Psychiatric Outpatients*, 146 Am. J. Psychiatry 755 (1989) (68% of thirty-one psychiatric outpatients questioned had experienced major physical and/or sexual abuse).

9. See, e.g., Jacobson & Herald, *The Relevance of Childhood Sexual Abuse to Adult Psychiatric Inpatient Care*, 41 Hospital & Community Psychiatry 154 (1990); Jacobson & Richardson, *Assault Experiences of 100 Psychiatric Inpatients: Evidence of the Need for Routine Inquiry*, 144 Am. J. Psychiatry 908 (1987).

related problems.[10] Moreover, the more invasive the sexual abuse, the more likely the victim will suffer long-term adjustment problems.[11] "Victims who had experienced abuse involving attempted or actual intercourse reported more marital disruption in adulthood, a lower level of satisfaction with their current heterosexual relationships, and a greater tendency not to practice any religion."[12] Adult survivors are more anxious, have more dissociative[13] and somatic symptoms, and have lower self-esteem than adults without a history of child abuse.[14]

---

10. Briere & Runtz, *Symptomatology Associated with Childhood Sexual Victimization in a Non-Clinical Sample*, 12 Child Abuse & Neglect 51 (1988); Stein, Golding, Siegel, Burnam & Sorenson, *Long Term Psychological Sequelae of Child Sexual Abuse: The Los Angeles Epidemiological Catchment Area Study*, in *Lasting Effects of Child Sexual Abuse* 135 (G. Wyatt & G. Powell eds. 1988).

11. D. Russell, *The Secret Trauma: Incest in the Lives of Girls and Women* (1986).

12. Finkelhor, Hotaling, Lewis & Smith, *Sexual Abuse and Its Relationship to Later Sexual Satisfaction, Marital Status, Religion, and Attitudes*, 4 J. Interpersonal Violence 379, 382 (1989).

13. Chu & Dill, *Dissociative Symptoms in Relation to Childhood Physical and Sexual Abuse*, 147 Am. J. Psychiatry 887 (1990).

14. Survivors of child sexual abuse are at significant risk of developing depression, various anxiety disorders, including post-traumatic stress disorder, substance abuse disorders, and sexual dysfunction. High rates of childhood sexual abuse are found in the histories of adults with conversion reaction, suicidality, self-mutilation, multiple personality disorder, borderline personality, chronic pelvic pain, and eating disorders. Childhood sexual abuse is found in a large percentage of adolescent prostitutes and runaways. See Berliner, *Effects of Sexual Abuse on Children*, 1 Violence Update 1 (1991).

Turning to the short-term effects of sexual abuse on children, numerous publications describe negative effects.[15] Common effects include fear and anxiety, feelings of guilt, depression, shame, anger, self-destructiveness, and inappropriate sexual or aggressive behavior.[16]

Given the widespread nature of child sexual abuse, and the harmful short- and long-term consequences of such abuse, it is clear that effective steps must be taken to protect society from individuals who sexually abuse children. The need for community protection is highlighted by research which discloses that "[m]ost prosecuted sex offenders have other, unreported victims. A small number of offenders have hundreds of victims."[17]

---

15. Berliner, *The Effects of Sexual Abuse on Children*, 1 Violence Update 1 (1991); J. Goodwin, *Sexual Abuse: Incest Victims and their Families* (1982).

16. See authorities collected in footnote 15, *supra*.

17. State of Washington, *Governor's Task Force on Community Protection* II-1 (1989).

For research discussing sex offenders with multiple victims see Abel, Becker, Mittelman, Cunningham-Rathner, Rouleau & Murphy, *Self-Reported Sex Crimes of Nonincarcerated Paraphiliacs*, 2 J. Interpersonal Violence 3 (1987). In this study, 561 male paraphiliacs were interviewed and asked to self-report deviant sexual conduct. To overcome resistance to admitting deviance, the men were guaranteed confidentiality. Among men who sexually abused children, the mean number of acts of child molestation was 23.2 for men who abused female children unrelated to the offender. The mean number of acts of child molestation was 281.7 per offender for men who abused male children unrelated to them. For perpetrators of incest, the mean number of acts involving female children was 81.3 compared to 62.3 for male children. Among rapists, the mean number of rapes per rapist was 7.2.

II. SEX OFFENDER TREATMENT IS AN IMPORTANT COMPONENT OF AN INTEGRATED SOCIETAL RESPONSE TO CHILD SEXUAL ABUSE

As society came to grips with the scope and seriousness of child sexual abuse, important changes occurred. The number of child sexual abuse prosecutions increased.[18] Prosecutors, law enforcement officers, and child protective services social workers received specialized training. Efforts were initiated to reduce the number of times children are interviewed, and to improve the quality of investigative interviews.[19] Legislatures and courts took measured steps to make the courtroom less traumatic for children.[20] Increased emphasis was placed on treatment for victims of child sexual abuse. States created specialized probation and parole units to monitor sex offenders in the community.

Along with the efforts described above, attention focused on the proper response to offenders. Society has long been uncertain about the appropriate disposition of individuals who sexually abuse children. Child sexual abuse is a serious crime in all jurisdictions. Nevertheless, many

---

See also, Weinrott & Saylor, *Self-Report of Crimes Committed by Sex Offenders*, 6 J. Interpersonal Violence 286 (1991).

18. B. Smith, S. Hillenbrand & S. Goretsky, *The Probation Response to Child Sexual Abuse Offenders: How is it Working?* 1 (American Bar Association, Criminal Justice Section, 1990)[hereafter cited as *ABA: The Probation Response*].

19. See California Attorney General's Office, *California Child Victim Witness Judicial Advisory Committee: Final Report* (1988).

20. *Maryland v. Craig*, 110 S. Ct. 3157 (1990).

convicted offenders are sentenced to probation, with a requirement that the offender participate in "treatment for the offender's sexual orientation to children."[21] With so many sex offenders "on the street," and at risk of reoffending, effective treatment is essential to community safety.[22]

When sexual abuse occurs within the family, many victims and non-offending parents prefer treatment for the offender. Indeed, in many intrafamilial abuse cases the primary reason for reporting sexual abuse and cooperating with law enforcement authorities is to obtain treatment and supervision for the offender. Victims and non-offending parents may hesitate to report abuse if the only possible outcome for the offender is incarceration.

Effective treatment depends on cooperation between treatment professionals and the criminal justice system,

---

21. *ABA, The Probation Response, supra* note 18 at 7. See *id.* at 3 ("Psychological counseling for the abuser was the offense-specific condition most often ordered for child sexual abuse probationers").

A number of states have sophisticated statutory schemes for alternative sentencing of selected sex offenders. See, e.g., Wash. Rev. Code Ann. § 9.94A.120(7) (1992 Cum. Pocket Part); Wash. Admin. Code §§ 246-930-010, 246-930-301 to 246-930-340.

22. To be effective, treatment must: (1) be tailored to the needs of the individual, (2) use treatment modalities which have the most promise, (3) be provided by a clinician with experience and sophistication in treating sex offenders, and (4) provide after care once formal treatment has ended.

Effective offender treatment is important because untreated offenders reoffend at higher rates than treated offenders. See section III, infra. Since virtually all child molesters eventually live in the community, public safety is enhanced when effective treatment is provided.

particularly courts and probation and parole officials. The courts play a critical role by mandating participation in treatment as a condition of probation or parole. Court-ordered treatment provides an important external motivator for offenders to enter and remain in treatment. Offenders are well aware that failure to participate in treatment may lead to incarceration. This external motivator keeps offenders engaged in treatment long enough for the therapeutic process to take root, replacing external control with self-motivation to control deviant sexual behavior.[23]

The second important function of the criminal justice system derives from the coordinated effort of therapists and probation and parole staffs to monitor the behavior of offenders in the community.[24] Most expert on offender treatment agree "that coordination between the therapist and

---

23. There is evidence that court-mandated treatment, along with penalties for not participating in treatment, increase participation. Abel and his colleagues conducted an extensive treatment program in which offenders were free to withdraw without adverse consequences. Abel found a 35% dropout rate from treatment. In treatment programs where participation was mandated by court order, the dropout was much lower. Abel, Mittleman, Becker, Rathner & Rouleau, *Predicting Child Molesters' Response to Treatment*, 528 Annals N.Y. Academy Sciences 223 (1988). No treatment program can be effective if offenders do not participate. Given the high cost of reoffending to victims and society, the use of court-mandated treatment as a mechanism to initially motivate offenders appears warranted.

24. See *ABA, The Probation Response*, *supra* note 18, where the report states:

> [C]lose communication and coordination between probation officers and treatment providers is important to monitor the offender adequately.

Id. at 9-10.

probation officer [is] critical to successful treatment of the offender."[25]

III. ALTHOUGH SEX OFFENDER TREATMENT IS INCREASINGLY SOPHISTICATED, TREATMENT GENERALLY CANNOT BE EFFECTIVE UNLESS THE OFFENDER ADMITS THE ABUSE

Historically, the treatment of sex offenders was based on the application of general mental health principles to this population.[26] That is, offenders were treated with psychotherapeutic and psychiatric techniques used with the broad array of psychiatric patients. Treatment was generalized, focusing on issues such as relationships with parents, early trauma, interpersonal relationships, and symptoms such as depression or anxiety. Early treatment efforts did not focus on sex offending per se, or on the situational factors leading directly to deviant sexual behavior. The goal of therapy was to "cure" the problem. Given the intractable nature of sexual deviancy, it is not surprising that the few early reports in the literature describe mixed results in terms of treatment effectiveness.[27]

Recent developments in the treatment of sex offenders differ in a variety of ways from earlier techniques. First, there is now widespread recognition that sexually deviant

---

25. *ABA, The Probation Response*, *supra* note 18 at 9.

26. See Myers, Bays, Becker, Berliner, Corwin & Saywitz, *Expert Testimony in Child Sexual Abuse Litigation*, 68 Neb. L. Rev. 1, 135–39 (1989).

27. Furby, Weinrott, & Blackshaw, *Sex Offender Recidivism: A Review*, 105 Psychological Bulletin 3 (1989).

thoughts and behaviors probably cannot be "cured." Thus, the focus of contemporary treatment is on techniques designed to help offenders control a life-long tendency toward deviant behavior. A second aspect of modern offender treatment is that treatment focuses on specific offending behaviors, and on the factors directly related to such behaviors.[28] A third component of modern treatment is the recognition by mental health professionals that the criminal justice system plays an indispensable role in getting offenders into treatment and keeping them there. The threat of incarceration provides the motivation necessary for many sex offenders to engage meaningfully in treatment. A fourth element of contemporary offender treatment also relates to the law. Mental health professionals recognize the importance of probation and parole officials as co-equal partners in monitoring offenders residing in the community.

For the most part, current models of sex offender treatment rely upon a cognitive behavioral approach to treatment. The focus of therapy is on preventing relapse rather than "cure."[29] Cognitive behavioral therapy concentrates specifically on the thoughts, feelings, and behaviors linked to sex offending. Efforts are made to assist offenders to recognize the psychological processes that allow offenders to maintain deviant behavior, and which increase the risk of reoffending.

There is increasing scientific evidence that the cognitive behavioral approach is effective in reducing

---

28. See Section III. D., *infra*.

29. Pithers, *Relapse Prevention with Sexual Aggressors: A Method for Maintaining Therapeutic Gain and Enhancing External Supervision*, in *Handbook of Sexual Assault: Issues, Theories, and Treatment of the Offender* (W. Marshall, D. Laws & H. Barbaree eds. 1990).

recidivism among sex offenders. Marshall and Barbaree studied offenders receiving outpatient treatment and found a four year recidivism rate of 25% for treated offenders versus 60% for nontreated offenders.[30] Other studies of outpatient treatment utilizing cognitive behavioral principles provide similar results. Wolfe found recidivism rates between 0% and 4.5%.[31] Maletsky found 5% to 14% recidivism.[32] Abel, Mittleman, Becker, Rathner, and Rouleau found rates of recidivism from 12% to 18%.[33]

Pithers and Cumming studied a group of sex offenders who received cognitive behavioral treatment while imprisoned.[34] Following release from prison, the offenders were followed for up to six years. The rate of recidivism

---

30. Marshall & Barbaree, *The Long-Term Evaluation of a Behavioral Treatment Program for Child Molesters*, 26 Behavior Research & Therapy 499 (1988).

31. Wolfe, *Northwest Treatment Associates: A Comprehensive Community-Based Evaluation and Treatment Program for Adult Sex Offenders*, in *Retraining Adult Sex Offenders: Methods and Models* (F. Knopp ed. 1984).

32. B. Maletsky, *Data Generated by an Outpatient Sexual Abuse Clinic*. Paper presented at the 1st Annual Conference on the Assessment and Treatment of Sexual Abusers, Newport, Oregon (May 1987).

33. Abel, Mittleman, Becker, Rathner & Rouleau, *Predicting Child Molesters' Response to Treatment*, 528 Annals N.Y. Academy Sciences 223 (1988).

34. Pithers & Cumming, *Can Relapse be Prevented? Initial Outcome Data from the Vermont Treatment Program for Sexual Aggressors*, in *Relapse Prevention with Sex Offenders* (D. Laws ed. 1989).

among this group of 137 child molesters was 3%.[35]

Treatment programs which yield the most promising recidivism rates share the components discussed below in subsections "A" through "F." When these components are operational, it is reasonable to conclude that state of the art offender treatment, although far from perfect, can significantly reduce recidivism, thus reducing the total number of victimized children. None of the essential components of modern offender treatment can be fully implemented until the offender admits that the abuse occurred.

A. Denial

Denial is a common phenomenon in offender treatment.[36] As treatment has become more sophisticated, methods for overcoming denial and encouraging honesty have been developed.[37] Certain offenders continue to deny the abuse, however, despite the best efforts of therapists.

---

35. In the Pithers and Cummings study, *supra* note 34, the offenders were closely monitored in the community. It is likely that this close supervision played an important role in achieving a low rate of recidivism.

36. Denial occurs on a continuum. At one end of the continuum is the offender who denies altogether that he committed the abusive act. Such denial makes treatment impossible. By contrast, an offender who acknowledges that he committed the act, but who denies that the act was harmful or wrong may well be amenable to treatment. Indeed, denial of the wrongfulness of conduct is common, and is often a focus of successful therapy.

37. Barbaree, *Denial and Minimization Among Sex Offenders: Assessment and Treatment Outcome*, 3 Forum on Corrections Research 30 (1991).

Regardless of the psychiatric problem for which a patient seeks treatment, common sense indicates that effective therapy is difficult if the patient denies there is a problem.[38] When denial occurs in the context of sex offender treatment, treatment difficulties multiply. By its very nature, sex offender treatment requires the offender to address issues related specifically to deviant sexual behavior. The offender must be willing to acknowledge and discuss a number of mental events related to deviancy. Maletzky describes the role of denial in treatment failure:

> The manner in which the patient regarded his offender behavior also bore some relevance to the issue of failing treatment. For example, the offender who wholly denied allegations of sexual abuse was three times as likely to fail than the offender who even partially admitted his complicity. Similarly, an offender who was totally opposed to treatment had a two and a half times greater likelihood of failing than the offender who at least minimally accepted (even if begrudgingly) the necessity of treatment.[39]

---

38. When a mental health professional determines that a psychiatric patient is not benefitting from treatment, the professional may have an ethical obligation to terminate treatment. See American Psychological Association, *Ethical Principles of Psychologists* (1990). Principle 6(e) states:

> Psychologists terminate a clinical or consulting relationship when it is reasonably clear that the consumer is not benefitting from it. They offer to help the consumer locate alternative sources of assistance.

39. B. Maletzky, *Treating the Sexual Offender*, 253–55 (1991).

In a practitioner's guide to treating sex offenders, the U.S. Department of Justice writes that the first goal of treatment is that "[t]he offender should be able to openly acknowledge guilt. This admission is a basic requirement for meaningful participation."[40] The clear consensus of professional opinion is that an offender who denies that abuse occurred cannot engage in the treatment process, rendering progress all but impossible.[41]

B. Cognitive Distortion

An important component of offender treatment consists of addressing and correcting the offender's cognitive distortions.[42] Cognitive distortions are thoughts and attitudes which allow offenders to minimize, justify, and rationalize their deviant behavior. Common cognitive

---

40. U.S. Department of Justice, *A Practitioner's Guide to Treating the Incarcerated Male Sex Offender: Breaking the Cycle of Sexual Abuse* 73 (1988).

41. See *ABA, The Probation Response*, *supra* note 18, where the report describes the position of therapists regarding the relationship between denial and successful therapy:

> With few exceptions, the therapists interviewed said they would not accept anyone in their program who absolutely denied sexual conduct with children. Most firmly believed that individuals who denied the abuse were not amenable to treatment.

Id. at 8.

42. Barbaree, *Denial and Minimization Among Sex Offenders: Assessment and Treatment Outcome*, 3 Forum on Corrections Research 30 (1991); Murphy, *Assessment and Modification of Cognitive Distortions in Sex Offenders*, in *Handbook of Sexual Assault: Issues, Theories, and Treatment of the Offender* (W. Marshall, D. Laws & H. Barbaree eds. 1990).

distortions include statements such as, "It was just sex education," "She was seductive" (referring to a seven-year-old), and, "I did it because my wife rejected me sexually." Cognitive distortions provide offenders an excuse to engage in deviant sexual behavior, and serve to reduce guilt. Treatment cannot go forward until the offender acknowledges the role of cognitive distortions and willingly discusses the use of such distortions prior to, during, and following sexual abuse. An offender who denies the abuse cannot accurately discuss cognitive distortions, thus undermining treatment.

C. Increasing the Offender's Ability to Empathize with the Victim

Lack of empathy for the victim is a common feature of adults who sexually abuse children. As with cognitive distortion, lack of empathy facilitates sexual abuse by insulating the perpetrator from the consequences of the offense. Thus, assisting offenders to come to terms with the significant negative impact of child sexual abuse--to have empathy with the victim--is a crucial step in treatment. The capacity to empathize with the victim increases the offender's ability to control the urge to engage in deviant sexual behavior. Offenders who do not admit the abuse do not explore the excuses used to justify such behavior, and are unlikely to develop empathy for the victim.

D. Risk Factors and Antecedents to Sexual Abuse

Current knowledge of deviant sexual behavior suggests that most sex offenses are not spur of the moment events. On the contrary, most offenses are planned, and it is possible--with the cooperation of the offender--to identify the sequence of events leading up to offenses. Each offender has a set of "risk factors" for deviant sexual behavior. One common risk factor is placing the offender in a situation

where offending is likely to occur, such as being alone with a child. Other risk factors include specific thoughts, fantasies, or behaviors which trigger a desire to engage in deviant sexual conduct. Risk factors are antecedent events that increase the probability of an offense. Identifying the offender's unique risk factors is an essential component of successful treatment. Identification of risk factors allows the therapist to teach the offender to detect the early warning signs leading to deviance, and to interrupt the chain of events before an offense occurs. The identification of risk factors is next to impossible when the offender denies that abuse occurred.

E. Increasing Social Competence

Sex offenders often have deficits in basic social skills. Many offenders are poor problem solvers, have poor anger or stress management skills, lack assertiveness, and lack skills for developing healthy adult relationships. One goal of offender treatment is to provide basic skills training to improve the offender's ability to deal effectively with social situations. Enhancing social competence requires ongoing monitoring and accurate self-reporting by the offender. When offenders deny the offense, the therapist has difficulty assessing the offender's development of appropriate social skills.

F. Sexual Arousal

There is ample scientific evidence that many offenders are sexually attracted to children.[43] Modern treatment methods are increasingly effective in altering patterns of

---

43. Murphy, Haynes, & Worley, *Assessment of Adult Sexual Interest*, in *Clinical Approaches to Sex Offenders and Their Victims* (C. Hollin & K. Howells eds. 1991).

deviant sexual arousal, or, at a minimum, teaching offenders to control their deviant arousal patterns.[44] For treatment to be effective, however, offenders must be willing to discuss deviant sexual urges and fantasies during treatment. The ability to assess and monitor deviant sexual arousal is severely limited in individuals who deny sexual abuse.

G. Summary

Several conclusions can be drawn from the foregoing discussion. First, there is reasonable consensus among experts on sex offender treatment regarding the major components of effective treatment. Second, recent research allows cautious optimism that treatment can reduce recidivism. Third, for treatment to be effective, the offender must be cooperative and willing to discuss thoughts, feelings, and behaviors surrounding the offense. In short, effective treatment requires the offender to admit that the abuse occurred.

CONCLUSION

Child sexual abuse is a serious social ill with terrible consequences for many victims. Modern offender treatment can reduce recidivism, thereby improving the lives of offenders and protecting children. The evidence is clear, however, that treatment is not effective for offenders who deny that abuse occurred. In the instant case, the Court can further society's effort to reduce child abuse by crafting a decision which accommodates the necessity in sex offender treatment of overcoming denial.

---

44. Kelley, *Behavioral Reorientation of Pedophiles. Can it be Done?*, 2 Clinical Psychology Review 387 (1992).

Respectfully submitted,

John E.B. Myers
American Professional Society on the Abuse of Children
3200 5th Ave.
Sacramento, CA 95817
(916) 739–7176